Authorization for Proxy Access to Patient Portal
Howard County Medical Center

Patient Name: Date of Birth:

_____

Email Address:

_____

(Please supply the email address of the person who will be using the patient portal)

I authorize the following individual to participate in Howard County Medical Center's Patient Portal as my proxy.

(*Please print*)

Proxy Name: Relationship to Patient:

_____

Date of Birth:

_____

Address:

_____

I understand that my proxy will have the same access and privileges that I have for the Patient Portal. I understand that this allows my proxy online access to my personal health information. My proxy will be able to view portions of my record that I am able to view. I also understand that additional information may be made available to my proxy through the patient portal as Howard County Medical Center continues to implement this product.

By signing this authorization, I am requesting Howard County Medical Center to give access to my proxy to utilize the patient portal. I understand that Howard County Medical Center will require my proxy to sign any acknowledgement and agree to Howard County Medical Center's policies and procedures for use of the patient portal.

This authorization is valid until revoked by me. I understand that a written request is necessary to revoke or cancel this authorization. However, I understand that my revocation will not be effective as to uses and/or disclosures already made in reliance upon this authorization. I realize that the information used and/or disclosed pursuant to this authorization may be subject to re-disclosure and no longer protected by federal privacy laws.

Patient Acknowledgment

_____ _____

Signature of Patient Date

Proxy Acknowledgment

_____ _____

Signature of Proxy Date